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Is Your Health Plan Unhealthy? Conditions, Symptoms, and Treatments

For large employers, self funding a health plan is without doubt the best way to manage health care costs. Despite this certainty, do you experience ongoing doubts as claims increase year-to-year? Are your doubts amplified when other managers (usually the CFO), armed with some new idea from a seminar attended or an article recently read, begin asking difficult questions about the plan: how it operates, why it's costing so much, and why it does not employ one strategy or another.

You need to determine whether or not your plan is in trouble. How should you identify the conditions, symptoms and warning signs, diagnose those signs and take action to correct problems to get your plan on the right track? This article will address some typical conditions, their underlying causes, related symptoms and treatment.

Condition - High claim levels

High claims do not necessarily mean the plan is failing, since utilization generally increases from year to year; large claims happen, sometimes several at once, so that costs may appear to be out of control. The key is to determine if these increases are being managed as well as possible, or whether they indicate an ailing plan.

Co-morbidities - High cost providers and utilization frequency

Today's health care environment is changing more rapidly than ever. As new physician practices and healthcare facilities emerge on a regular basis, the self funded plan manager must keep up. Plans that fail to closely examine their network utilization and associated charges can become ineffective at controlling costs, as their members seek care from the highest cost providers and facilities. This is a sure sign a plan is not on the right track and will likely continue to experience rising costs.

Treatment - Monitor claims and utilization regularly

Effective plans monitor utilization on a quarterly or monthly basis, including costs, charges and discounts. Look for spikes or unusual occurrences, like abnormally high charges. The cause of these anomalies can vary. Some are routine, but others could result from changes in network or contract status of a particular provider, or the emergence of a new provider. Be prepared to make mid-year changes to networks or even to benefit design, to protect against runaway costs driven by external changes.



Dig deeper - Explore networks and treat the causes.

When you are examining existing networks, consider charges from both facilities and physicians. Determine where your population is getting care and whether those services are being provided by the lowest or highest cost providers within your network. Watch out for high cost free-standing surgical centers. Identify high charges from unique physician groups and monitor where those physicians are performing their services. Once you have identified high cost providers, consider negotiating with those providers. For instance, you might restrict them to your out-of-network tier, or you might eliminate coverage at those facilities or physicians altogether, if services with similar quality and outcomes are available in other venues.

Analyze the relationship between high claims levels and utilization frequency. Accelerated claim levels from period to period, without an associated spike in utilization frequency, can indicate that you are paying higher costs for the same amount of services. This can be indicative of a change in network discounts, or of the difference between one network and another, if you have recently changed networks, carriers, or third party administrators. Remember that network discounts are where the real money is. Don't chase savings by looking to lower administration costs; these represent only a small fraction of the total cost.

Condition - Adverse selection

Adverse selection is probably one of the hardest conditions to diagnose in an ailing plan and may go undetected. It is commonly caused by multiple plan offerings, which increase plan expenses.

Symptoms are not readily apparent, as adverse selection does not present with overt signs like high cost claims. Statistics show that only about 5% of the population accounts for nearly 40% of claims, while nearly 60% account for less than \$1,000 each in annual claims. Thus, where the members of these populations enroll, and what they contribute in payroll deductions, can dramatically affect your plan's financial performance.

Co-morbidities - Fully insured plans and opt-out credits

Consider the offer of any fully insured product, like a community-rated HMO, alongside a self funded plan. If healthy individuals elect the fully insured plan, you will trade low claim costs for high fixed premiums. Opt-out credits may only be costing you money, rather than achieving your intentions.

Treatment - Price plans correctly and eliminate opt-out credits

Optimize enrollment by pricing plans according to their actuarial difference, and not solely on the plan's experience. Pricing based on the plan's experience may cause migration of low-cost healthy individuals to the plan with the lowest contribution, eroding gross employee premium contributions. Regardless of the



number of plans offered, the plan is responsible for the aggregate of all claims of the population; therefore, enrollment should be as balanced as possible among all plans, with each one carrying its fair share of both sick and healthy people. This allocation ensures that you will maximize employee aggregate contributions to your plan.

With respect to opt-out credits, the initial intent of these credits was to incent individuals to enroll in another employer's plan, as a cost-saving initiative. If your plan mirrors the current market in benefit levels and cost share, and is not a "plan of choice", those who opt out are likely to continue to do so, given the payroll contribution for participating in your plan. For those who do now enroll, remember that 60% of individuals have less than \$1,000 in annual claims. By charging even a modest amount per month of payroll contribution, the odds are that you will collect more in payroll contributions from the majority of the former opt-out population than you will pay in claims. This influx comes on top of savings derived from eliminating the opt-out credit.

Condition - Ineffective stop loss protection

A poorly structured stop loss contract characterizes a self funded plan that is destined for a crash. This condition can manifest itself in many ways, from an impression that the plan's fixed costs are too expensive, to an observation that large claims are never reimbursed by the stop loss.

Co-Morbidity - Coverage gaps and inappropriate deductible levels

Contracts with low deductibles, gaps in stop loss contract provisions and variances between the plan document and the stop loss coverage can cause significant pain and discomfort. Fortunately these symptoms can be treated.

Treatment - Lifestyle changes

A hallmark of a self funded plan is an appropriate assumption of risk. However, many risk averse plan administrators attempt to shed as much risk as possible, by setting the stop loss deductibles so low and the accompanying premium so high, that the plan might be better off fully insured. Set stop loss deductibles high enough that premiums don't eat into the savings garnered by self funding. This can be a difficult lifestyle change for an organization that is particularly risk averse. However, managing networks as described above will go a long way toward controlling costs. Remember, plans that attempt to hand off high costs to someone else eventually pay those costs in any case.

Ensure stop loss provisions, like incurred periods and paid periods, line up with expectations. It is always possible that a large claim that has been incurred in December and continues into January may slip by the stop loss thresholds of both contract years, leaving the plan to pay 100% of the charges. Ensure that you have the proper run-out and run-in protection, as opposed to a low deductible.



Make sure that the plan document is aligned with the stop loss contract's limits and exclusions. Your plan document should not cover a service that is excluded under your stop loss contract, including eventual lifetime dollar limits on essential benefits. Under healthcare reform, we are marching towards unlimited lifetime maximums for all plans, grandfathered or not.

Condition - Commitment phobia

That common expression reflects the depth of a commitment to somebody or something. Unfortunately it can be applied to self funded plans, because too many organizations have trouble committing to what it takes to be a self funded plan – ensuring sufficient reserves.

Treatment - Behave like an insurance carrier.

Ineffective self funded plans tend to reject the notion that they are largely acting like an insurance carrier. Self funded plans accept risk, collect premiums, adjudicate claims, and sometimes make claim fiduciary decisions- all functions similar to those of an insurance carrier. Like a carrier, self funded plans should set aside reserves from year to year. Avoid the pitfall of assuming a low claim year will reoccur. Accumulate reserves during the good years to build a bulwark against high claims and utilization during the lean years. Once self funded, you need to commit to following all the appropriate disciplines in order to be successful. Measure the plan's success over the long run, and not just during the past 12 months.

Condition - Specialty drug addiction

High levels of Rx utilization among specialty drugs can cost a plan dearly. In the past, specialty drugs were usually reserved for rare, short-term conditions; now, pharmaceutical manufacturers are increasingly producing specialty drugs that treat common, long-term chronic conditions.

Co-Morbidity - Rx cost increases consistently above trend

Understanding the complexities of pharmaceutical contracts may be challenging. Average wholesale price, discounts and rebates can be difficult to quantify. As a rule, if your Rx costs are consistently above trend, it's a pretty good bet you are not getting a good deal.

Treatment

Negotiate prescription drug contracts with guaranteed rebates and periodic auditing and reconciliation if contractual guarantees are not attained. Look for specific utilization management opportunities that address your plan's prescription use, instead of generic "catch all" programs. All major pharmacy benefit managers produce detailed utilization reports. Make sure that yours also generates ideas to change utilization and lower costs. Ensure appropri-



ate utilization of specialty drugs and engage in physician outreach to modify prescribing habits, which saves both the plan and the patient money.

Condition - Myopic vision

Too many plan administrators don't perceive clearly and fully what's going on in their plan.

Treatment - Plan audit

The best run self funded plans conduct independent claims audits at regular intervals, typically a thorough review every three years. More frequent eligibility audits may also be warranted, as well as verification of plan coverage rules to ensure services being paid for are indeed covered services under the plan. Look for subrogation opportunities, know your subrogation process, and check that it is being followed. Does your plan pay and pursue or pursue and then pay? Verify network discounts are being applied correctly and that the actual plan design, like cost share, is being administered properly.

Focus on ancillary functions

Administrative packages include a variety of ancillary services, like wellness, care and disease management. As integral elements of your plan, these must prove themselves effective. Measure return on investment of these programs and discontinue those with no evidence of efficacy. Evaluate clinical outcomes to ascertain whether your care management program actually engages the individuals targeted. Keep an eye out for new ancillary services and products that periodically emerge on the scene, like access management services that provide individuals with cost and quality data for various providers that offer particular services. These programs can help steer members to lower cost, high quality providers.

Summary

Today's health care space is more dynamic than ever. Regulatory changes, a changing marketplace among provider groups, hospital mergers and consolidations all pose new challenges. Running a successful self funded plan has never been so daunting. Despite the complexities, the self funded plan is best positioned to react to this state of flux. Managers who can recognize the effect of various market forces will be best positioned to establish and maintain successful plans.

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